Registered Nurse/Practical Nurse Expired License Activation Application Packet

Contents:

Important Social Security Number Information:

You are required by state and federal law to provide a social security number with your application. If you do not have a social security number, please read, complete, and return this **form** with your application.

A U.S. Individual Taxpayer Identification Number (ITIN) or a Canadian Social Insurance Number (SIN) cannot be substituted.

In order to process your request:

Mail your application with initial documentation and your check or money order payable to:

Department of Health
PO Box 1099
Olympia, WA 98507-1099

Send other documents not sent with initial application to:

Nursing Commission
PO Box 47864
Olympia, WA 98504-7864

Contact us:

360.236.4703

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Washington State Department of Health

Application Instructions Checklist

All information should be typed or printed clearly in blue or black ink.

To ensure that you have submitted the necessary fees and documentation, we encourage you to use the following checklist:

☐ **Application Fee**. This fee is non-refundable. You can check the online **fee page** for current fees.

☐ **1. Demographic Information:**
Social Security Number: You must list your social security number on your application. If you do not have a social security number, please read, complete, and return this **form** with your application.

Legal Name: List your full name: first, middle, and last.

Definition of legal name: "Legal name" is the name appearing on your official certificate of birth or, if your name has changed since birth, on an official marriage certificate or an order by a court. The court must have the legal authority to change your name. We may ask you to prove your legal name. If you use any name other than your legal name on this form, your application may be denied.

Birth date: Provide the month, day, and year of your birth.

Birth place: Provide the city, state and country where you were born.

Address: List the address we should use to send any information about your license. Be sure to include the city, state, zip code, county, and country. This will be your permanent address with the Department of Health until we have been notified of a change. See **WAC 246-12-310**.

Phone, Fax and Cell Numbers: Enter your phone, fax and cell numbers, if you have them.

Email: Enter your email address. Email is our primary for of communication. Join our **ListServ**.

Other Name(s): Indicate whether you are known or have been known under any other names. If you have a name change, you must notify the Department of Health in writing. You must include proof of this change. See **WAC 246-12-300**.

☐ **2. Personal Data Questions:**
All applicants must answer the same personal data questions. They are focused on your fitness to practice the essential skills of this profession.

If you answer "yes" to any questions in this section, you must provide an appropriate explanation. You must also provide the documentation listed in the note after the question. If you do not provide this, your application is incomplete and it will not be considered.

- Question 5 includes misdemeanors, gross misdemeanors and felonies. You do not have to answer yes if you have been cited for traffic infractions. You can get copies of court records through the county courthouse where the conviction, plea, deferred sentence, or suspended sentence was entered.
- Another jurisdiction means any other country, state, federal territory, or military authority.

☐ **3. Other License, Certification, or Registration:**
List **all** licenses you have held since last being licensed in Washington State. List in date order, most current first. Include your last active licensed in Washington State. Attach additional completed pages if you need more space.

☐ **4. Previous Work History:**
Check One: Currently Working as RN/LPN in another state or jurisdiction or Not currently working as RN/LPN.

☐ **5. AIDS Education and Training Attestation:** Required by **WAC 246-12-040**.

☐ **6. Disciplinary Action Attestation:** Required by **WAC 246-12-040**.

☐ **7. Applicant's Attestation:** Required to be both signed and dated in order to process the application.

Please note: You will be notified in writing if more documentation is needed. Please try to avoid calling to check on the status of your application. This will allow program staff to process your application file with fewer interruptions.

- The application is incomplete if requested information is left blank. Fill in N/A or place a line through section instead of leaving blank.
- The initial license will expire on your birthday unless the license is issued within 90 days of your next birthday. See **WAC 246-12-020(3)**.

Washington State Department of Health

Activation Requirements

1. **Inactive license status less than three years. Note: Inactive is not expired.**
2. **Stop!** No application is required. Pay inactive renewal fee.
3. **Inactive license status more than three years.**
   - Send in application with fees, and include a copy of a current/active license from another state. If you do not have a current/active license in another state, complete a state approved refresher program.
   - **Be sure** to check the box on front of the application next to Limited Education Authorization, if applicable.
   - After your application is reviewed, a letter giving you the authority to complete the clinical portion of the refresher program will be sent to you. After you successfully complete the program and the Nursing Commission receives a letter from the program director, a valid license will be issued to you.
4. **Expired license more than one year, but less than three years.**
   - Send in application with fees.
5. **Expired license for more than three (3) years**
   - Send in application with fees, and include a copy of a current/active license from another state. If you do not have a current/active license in another state, complete a state approved refresher program.

   Be sure to check the box on front of the application next to Limited Education Authorizations, if applicable.
   - After your application is reviewed, a letter giving you the authority to complete the clinical portion of the refresher program will be sent to you. After you successfully complete the program and the Nursing Commission receives a letter from the program director, a valid license will be issued to you.

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Nurse Refresher Programs

The following are Washington State approved refresher nursing courses. Successful completion of an approved course is required for return to active status of a Registered Nurse/Licensed Practical Nurse license that has been inactive or lapsed three or more years. Scheduling and fees very. Please contact the program directly for more information.

RN Programs

Name of Program	Type	Contact	Comments
Bellevue Community College	On Line On Campus	Melissa Meinhofer (425) 564-2702 **Website**	Spring—Online Fall—On campus
Everett Community College	On Campus	(425) 338-9471 **Website**	8 weeks of Summer (June—August)
Pacific Lutheran University			Not currently offering
Washington State University College of Nursing	Self Study	Ryan Townsend (509) 324-7354 **Website**	Theory component: Self study Clinical component: Sites vary
South Dakota State University	Self Study	Sandy Malone (605) 688-5745 **Website**	Theory component: Self study Clinical component: Must be 160 hours
A New Day: RN Refresher Online Program	Online/Virtual Self Paced	Sandy Wyrick (425) 478-0779 **Website**	Theory component: Virtual and Online Clinical component: setting based on applicant's residence

LPN Programs

Name of Program	Type	Contact	Comments
Bates Technical College	Self Study	Eileen Beck (253) 680-7368 **Website**	Theory component: Self study Clinical component: applicant must establish
South Dakota State University	Self Study	Sandy Malone (605) 688-5745 **Website**	Theory component: Self study Clinical component: Must be 120 hours
Innovative Academic Solutions	Online	1-800-479-2805 **Website**	Theory component: Self study Clinical component: Must be 120 hours

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Washington State Department of Health

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Revenue 025801000

Registered Nurse Practical Nurse Expired License Activation Application

☐ Registered Nurse Activation ☐ Licensed Practical Nurse Activation ☐ Limited Education Authorization

1. Demographic Information

Social Security Number (If you do not have a social security number, see instructions)

☐ Male
☐ Female

Name	First	Middle	Last

Birth date (mm/dd/yyyy)	Place of birth		
	City	State	Country

Address			
City	State	Zip Code	County
Country			

Phone (enter 10 digit #)	Fax (enter 10 digit #)	Cell (enter 10 digit #)

Email address:

Mailing address if different from above address of record

City	State	Zip Code	County
Country			

Note: The mailing and email addresses you provide will be your addresses of record. It is your responsibility to maintain current contact information on file with the department.

Have you ever been known under any other name(s)? ☐ Yes ☐ No If yes, list name(s):

Will documents be received in another name? ☐ Yes ☐ No If yes, list name(s):

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Review for: ☐ FBI ☐ HIPBB ☐ WSP ☐ PDQ ☐ NOD

☐ Approved per policy A21.05 delegated decision making for selected license applications

☐ Forward to CMT ☐ Approved by CMT ☐ Denied by CMT

☐ Proceed with licensing process _____

2. Personal Data Questions

Yes No

1. Do you have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please attach explanation. ☐ ☐

   "Medical Condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, intellectual disabilities, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction, and alcoholism.

   If you answered yes to question 1, explain:

   1a. How your treatment has reduced or eliminated the limitations caused by your medical condition.

   1b. How your field of practice, the setting or manner of practice has reduced or eliminated the limitations caused by your medical condition.

Note: If you answered "yes" to question 1, the licensing authority will assess the nature, severity, and the duration of the risks associated with the ongoing medical condition and the ongoing treatment to determine whether your license should be restricted, conditions imposed, or no license issued.

The licensing authority may require you to undergo one or more mental, physical or psychological examination(s). This would be at your own expense. By submitting this application, you give consent to such an examination(s). You also agree the examination report(s) may be provided to the licensing authority. You waive all claims based on confidentiality or privileged communication. If you do not submit to a required examination(s) or provide the report(s) to the licensing authority, your application may be denied.

2. Do you currently use chemical substance(s) in any way which impair or limit your ability to practice your profession with reasonable skill and safety? If yes, please explain. ☐ ☐

   "Currently" means within the past two years.

   "Chemical substances" include alcohol, drugs, or medications, whether taken legally or illegally.

3. Have you ever been diagnosed with, or treated for, pedophilia, exhibitionism, voyeurism or frotteurism? ☐ ☐

4. Are you currently engaged in the illegal use of controlled substances? ☐ ☐

   "Currently" means within the past two years.

   Illegal use of controlled substances is the use of controlled substances (e.g., heroin, cocaine) not obtained legally or taken according to the directions of a licensed health care practitioner.

Note: If you answer "yes" to any of the remaining questions, provide an explanation and certified copies of all judgments, decisions, orders, agreements and surrenders. The department does criminal background checks on all applicants.

5. Have you **ever** been convicted, entered a plea of guilty, no contest, or a similar plea, or had prosecution or a sentence deferred or suspended as an adult or juvenile in any state or jurisdiction? .. ☐ ☐

Note: If you answered "yes" to question 5, you must send certified copies of all court documents related to your criminal history with your application. If you do not provide the documents, your application is incomplete and will not be considered.

To protect the public, the department considers criminal history. A criminal history may not automatically bar you from obtaining a credential. However, failure to report criminal history may result in extra cost to you and the application may be delayed or denied.

2. Personal Data Questions (cont.)

Yes No

a. Are you now subject to criminal prosecution or pending charges of a crime in any state or jurisdiction? ☐ ☐

Note: If you answered "yes" to question 5a, you must explain the nature of the prosecution and/or charge(s). You must include the jurisdiction that is investigating and/or prosecuting the charges. This includes any city, county, state, federal or tribal jurisdiction. If charging documents have been filed with a court, you must provide certified copies of those documents. If you do not provide the documents, your application is incomplete and will not be considered.

b. If you answered "yes" to question 5a, do you wish to have decision on your application delayed until the prosecution and any appeals are complete? ☐ ☐

6. Have you ever been found in any civil, administrative or criminal proceeding to have:

a. Possessed, used, prescribed for use, or distributed controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes? ☐ ☐

b. Diverted controlled substances or legend drugs? ☐ ☐

c. Violated any drug law? ☐ ☐

d. Prescribed controlled substances for yourself? ☐ ☐

7. Have you ever been found in any proceeding to have violated any state or federal law or rule regulating the practice of a health care profession? If "yes", please attach an explanation and provide copies of all judgments, decisions, and agreements? ☐ ☐

8. Have you ever had any license, certificate, registration or other privilege to practice a health care profession denied, revoked, suspended, or restricted by a state, federal, or foreign authority? ☐ ☐

9. Have you ever surrendered a credential like those listed in number 8, in connection with or to avoid action by a state, federal, or foreign authority? ☐ ☐

10. Have you ever been named in any civil suit or suffered any civil judgment for incompetence, negligence, or malpractice in connection with the practice of a health care profession? ☐ ☐

3. Previous Credentialing (Include Previous Credentials in Washington State)

State/Jurisdiction	Profession RN or LPN	Credential		Method of Credentialing		License is Active?	
		Number	Year Issued	Exam	Endorsement	No	Yes

4. Previous Work History

☐ Currently Working as RN/LPN in another state or jurisdiction.

☐ Not currently working as RN/LPN.

5. AIDS Education and Training Attestation (Check Appropriate Box)

I certify I have completed the minimum of seven hours of education in the prevention, transmission and treatment of AIDS. This includes the topics of etiology and epidemiology, testing and counseling, infection control guidelines, clinical manifestations and treatment, legal and ethical issues to include confidentiality, and psychosocial issues to include special population considerations.

I understand I must maintain records documenting said education for two years and be prepared to submit those records to the department if requested. **I understand that should I provide any false information, my license may be denied, or if issued, suspended or revoked.**

APPLICANT'S INITIALS

6. Disciplinary Action Attestation

I certify no action has been taken by any state or federal jurisdiction or hospital, which would prevent or restrict my right to practice my profession.

I further certify I have not voluntarily given up any credential or privilege or have not been restricted in the practice of my profession in lieu of or to avoid formal action.

APPLICANT'S INITIALS

7. Applicant's Attestation

I, _____ , declare under penalty of perjury under the laws of the state of
(Print applicant name clearly)
Washington the following is true and correct:

- I am the person described and identified in this application.
- I have read **RCW 18.130.170** and **RCW 18.130.180** of the Uniform Disciplinary Act.
- I have answered all questions truthfully and completely.
- The documentation provided in support of my application is accurate to the best of my knowledge.

I understand the Department of Health may require more information before deciding on my application. The department may independently check conviction records with state or federal databases.

I authorize the release of any files or records the department requires to process this application. This includes information from all hospitals, educational or other organizations, my references, and past and present employers and business and professional associates. It also includes information from federal, state, local or foreign government agencies.

I understand I must inform the department of any past, current or future criminal charges or convictions. I will also inform the department of any physical or mental conditions that jeopardize my ability to provide quality health care. If requested, I will authorize my health providers to release to the department information on my health, including mental health and any substance abuse treatment.

Dated _____ _____ in
(mm/dd/yyyy) (City, state)

By: _____
(Signature of applicant)

RCW/WAC and Online Web Site Links

RCW/WAC Links

Uniform Disciplinary Act ..... UDA RCW 18.130

Administrative Procedure Act ..... APA RCW 34.05

Administrative procedures and requirements ..... WAC 246-12

Nursing Care Laws ..... RCW 18.79

Nursing Care Rules ..... WAC 246-840

How To Return To Active Status From Expired Status ..... WAC 246-12-040

On-Line

AIDS Training Resources ..... Reference Page

Nursing Commission ..... Web Page